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Disrupting the norms: Reproduction, gender identity, gender dysphoria, and intersectionality

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ABSTRACT

Background: In western cultures, pregnancy and birth have typically been viewed as inherently feminine activities. However, some transmasculine individuals desire and undergo pregnancy.

Aims: Our study aimed to explore the experiences of transmasculine individuals with pregnancy and birth.

Methods: We conducted 22 qualitative interviews and four follow-up interviews with transmasculine individuals who had experienced one or more pregnancies. Our analysis was guided by an intersectional approach, and was led by a transgender community member.

Results: The interviews focused on stories about how the study participants built their families and navigated health care systems in the context of being pregnant transgender persons. As part of a larger study that considered the pregnancy, birth and infant feeding experiences of transmasculine individuals, this paper examines three themes that emerged from the narratives: experiences of gender dysphoria, addressing the gender binary, and intersectionality.

Discussion: Experiences of gender dysphoria among transmasculine individuals during pregnancy and birth vary widely. Some trans individuals experience pregnancy as congruent with their masculine gender identity. However, participants reported that some health care providers' strong belief in the gender binary led to inappropriate and oppressive reproductive and perinatal health care.

KEYWORDS

Childbirth; gender binary; gender dysphoria; intersectionality; pregnancy; transgender; transmasculine

Introduction

In western cultures, pregnancy and birth are typically still recognized as strictly and explicitly feminine desires and experiences. Western cultures not only portray pregnancy as an inherently feminine activity; they often seem obsessed with pregnancy as feminine (Walks, 2013). At the same time, the assumption is that a transgender man born with what is viewed as typical female anatomy should wish to change as much of his body as possible to become masculine, for example, by taking testosterone, having male chest contouring surgery, and having his uterus removed. According to these beliefs, a transgender man should not desire to be pregnant.

For decades, legal systems and state apparatuses across Europe, North America, Asia, and parts of Africa have imposed a narrative that prohibits trans reproduction by requiring transmasculine people to undergo sterilization surgeries or hysterectomies in order to be legally recognized as male (Open Society Foundations, 2014). While some of these jurisdictions have dropped the surgical requirement, this is a fairly recent development (circa 2010) and is not universal. Despite these legal and social barriers, transmasculine individuals can and sometimes do become pregnant, including after previous testosterone use or male chest contouring surgery (Ellis et al., 2015; Light, 2014).

A study of 50 Dutch-speaking trans men found that 54% of participants desired children (Wierckx, 2012), and a US study found that 38%

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of trans individuals are parents (Grant et al., 2011). Researchers of these studies did not distinguish between trans men who are genetically related to their children, and trans parenthood in general. Growing anecdotal evidence from sources such as online support groups suggests that increasing numbers of transmasculine individuals are planning pregnancies and having children (Facebook.com, 2012 to present). A Canadian study found that nearly one in twenty trans youth had experience with pregnancy involvement, although the study did not distinguish between planned and unplanned pregnancies (Veale, 2016). The authors noted that this rate is similar to that of the general youth population.

Major health-related organizations are calling on their members to become educated about appropriate transgender care and to eliminate discrimination in their practices. The American College of Obstetricians and Gynecologists (Health care for transgender individuals, 2011) issued a statement in December 2011, urging OB/GYNs to provide adequate preventive care to transgender people. The organization also noted that more research is needed among the transgender population. Similarly, in December 2012, the American College of Nurse Midwives published a Position Statement (2012) instructing its members to learn how to be sensitive to the needs of transgender and genderfluid individuals. Both of these professional groups endorse the current guidelines set forth in 2011 (Coleman et al., 2012) by the World Professional Association for Transgender Health, which include the recommendation that transgender people receive counseling regarding their reproductive options.

Several research projects have focused on trans men's experiences with pregnancy. More (1998) investigated the experiences of nine trans men with pregnancy, birth and breast or chestfeeding. All of More's study participants transitioned medically after their last child was born, although six were aware of their transgender identities at the time of pregnancy (More 1998). More found that the experience of pregnancy did not feminize participants' sense of their own gender identity, and in some cases it made their masculine identity more apparent to the individual. In addition to their joy in anticipating becoming a parent, participants expressed fears surrounding discrimination and possible loss of custody, and shame about being perceived as female and misgendered. More concluded that excessive stress, depression, and even suicidality could be risk factors when participants' support networks were inadequate, but were less likely to occur when participants had family, friends, and health care providers who accepted and acknowledged their male gender identity.

In 2014, Light et al. published the results of an online survey with 41 trans men who had experienced pregnancy after transitioning. Participants were asked closed-ended questions regarding demographics, hormone use, fertility, pregnancy experience, birth experience, and fetal outcomes. There were four open-ended questions that covered the participants' experiences with health care professionals. Light found low levels of health care provider awareness of the needs of pregnant transgender men. In a 2015 study, Ellis et al. interviewed eight trans and gender-variant individuals who had experienced pregnancy, and concluded that loneliness was a main qualitative theme among participants.

A qualitative study by Hoffkling et al. (2017) found much variability in terms of reproductive intent, fecundity, gamete sources, and access to social supports among transgender men experiencing pregnancy. The authors found that study participants used a wide range of terms to describe their masculinity. They noted complex and varied decisions about being "out" as either transgender or as pregnant, and also regarding the sequence of transition (social and medical) and pregnancy. Study participants described experiences with health care providers that included a lack of cultural competency and outright transphobia, as well as more empowering relationships. An Australian study (Charter, 2018) similarly examined transgender pregnancy using an online survey and one-on-one interviews with 25 participants.

Our research study asked the question, "What are the experiences of transmasculine individuals with pregnancy, birthing, and feeding their newborns?" This paper focuses on the interview participants' experiences with pregnancy and birth, particularly with respect to the belief in, or challenge of, the gender binary; experiences of gender

dysphoria; and intersectionality. The purpose of this article is to serve as a foundation for further research; to be useful for trans and genderqueer people who are considering a pregnancy; to create resources for health care professionals; and finally to highlight the effects of clinical care and childbearing-year experiences on trans lives. Building on Walks' (2013) previous work, as well as the work of Pyne (2012), Huberdeau (2014), Ellis et al. (2015), Light (2014), and Hoffkling (2017), we focus here on the ways that the narratives of our study participants challenge the assumptions that gender is binary, that pregnancy is inherently feminine, and that all transmasculine individuals feel the same ways in their bodies.

Method

The project

This paper describes transmasculine individuals' experiences with pregnancy and birth, with particular attention to the themes of gender identity and gender dysphoria. It is taken from our larger interdisciplinary and community-based research project that sought to find out how transmasculine individuals experience pregnancy, birth, and infant feeding.

The idea for the project was Trevor Kirczenow MacDonald's, due to his own experience of pregnancy, birth, and chestfeeding with his two children. He directed the focus of the project.

Ethics

This study was approved by the Health Sciences and Science Research Ethics Board at the University of Ottawa, Ontario, Canada. The approval is based on the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (2nd edition). Participants provided informed consent in writing or verbally on a digital recording after having opportunities to ask questions about the research.

Study design

The findings reported in this article are based on in-depth, semi-structured interviews, 1–2 hours each, conducted with 22 transmasculine individuals from North America, Australia, and Europe, who had experienced one or more pregnancies. We recruited a convenience sample of participants mostly through the internet. A letter was posted to the Facebook page, "Birthing and Breast or Chestfeeding Trans People and Allies" that Trevor Kirczenow MacDonald manages, while a poster was circulated via email (Facebook.com, 2012 to present). Our call for participants included individuals who self-identified as transmasculine and had experienced or were currently experiencing pregnancy. We used the term "transmasculine" broadly in our call for participants, including anyone who experienced pregnancy yet did not identify as exclusively feminine, and who wished to discuss their experiences. Ultimately, some participants answered our call and then defined their gender identities with more nuance beyond the word "transmasculine" in their interviews. Those who identified as genderqueer or non-binary were included in the study.

There was no requirement regarding medical or social transition. Some participants had taken testosterone and/or had chest surgery before their pregnancies, while others had not. Inclusion was not restricted by geography, but all interviews were in English.

Data collection

Trevor coordinated the recruitment of participants and conducted interviews from September 2014 to October 2015. It was important to the research team and participants that it was a fellow transmasculine individual who was conducting the interviews—someone who could relate to at least some of their experiences. Interviews were transcribed verbatim, de-identified, and then shared with the team.

Analytic approach

Our analysis was guided by an intersectional approach, and was led by a transgender community member. We followed the interpretive description methodology and constant comparative techniques developed by Thorne et al (1997). All authors, including clinicians in midwifery and lactation, read each interview as the transcripts

became available, and provided ongoing feedback to the interviewer. After all interviews were completed, the first and second authors coded the interviews independently from one another. All authors compared the codes to confirm that they represented the most important topics contained in the interviews. The first and second authors then worked together to extract the themes that emerged from the codes.

Results

Participants

Of the 22 participants, 20 had carried babies to term at the time of their interviews (one was still pregnant and one had miscarried). Fourteen participants had one child. Eight participants reported that they had experienced miscarriage and two participants mentioned that they had an abortion. Two participants mentioned that their pregnancies were not planned. Nine participants had taken testosterone before they conceived, eight had started taking it for the first time after their children were born, and five had never taken it.

For ethnicity, we used an open question ("what is your ethnic background?"). Thirteen participants used race as a means of identifying ethnicity: ten White or Caucasian; two Black; and one non-Hispanic. Some participants used their nationality (e.g. Canadian) to describe their ethnic background, and three stated they were Jewish.

We did not ask specifically about disabilities in our demographics questionnaire, but during interviews, two participants mentioned that either they were disabled or they had a partner or close friend with a disability who was involved in their pregnancy and birth.

Study participants used a variety of terms to refer to themselves as parents. Seven participants who transitioned before the start of their pregnancies went by the title "dad" or "daddy." Several parents used non-English parent titles meaning "dad." Five participants chose gender-neutral or genderfluid parent titles that were formed by combining two terms associated with different genders from one or more languages. One parent's child called him by his first name. For five participants, all of whom transitioned after giving birth, their children used the title "mom" or "mommy." Of the 22 participants, 20 participants said they used male pronouns and two used neutral pronouns or both "he" and "she." When we discuss participants' stories and quote their narratives, pseudonyms are used and identifying information (including country of origin, ethnicity, and age) is not given, in order to protect the participants' identity.

During interviews, participants frequently mentioned the gender binary and how they perceived pregnancy in relation to it, as well as their experiences of bodily gender dysphoria. These themes speak to participants' own sense of identity and their feelings about their bodies during pregnancy and birth. More broadly, many participants also reflected on how their trans identity fit into their wider life context in an intersectional way.

Understanding gender dysphoria

Gender dysphoria is distress, discomfort, and discordance that many but not all trans people feel with relation to their body or gender presentation being incongruent with the sex or gender they see themselves as (Coleman et al., 2012). In our research, some participants experienced gender dysphoria due to pregnancy-related body changes that they perceived to be feminine, and contrary to their transmasculine sense of self, while others did not experience pregnancy-related gender dysphoria. For those who did experience it, they described bodily gender dysphoria (in contrast to socially triggered gender dysphoria) in many different ways.

Two participants, Dagan and Ben, who had unplanned pregnancies mentioned that they did not believe their bodies could become pregnant. Both identified as transgender or genderqueer at the time of conception, and neither had been using testosterone. They did not see their bodies as female, but identified pregnancy as a "female-bodied" activity that could trigger feelings of gender dysphoria.

> Dagan: I didn't realize that – it might sound stupid – but I didn't realize that my body could get pregnant … I didn't realize it was something my body

could do. So, when it happened, I was like, oh right, this is the female-bodied part of me, isn't it? So, it took some time for me to catch up to it because it was unplanned, clearly … So once I kind of caught up to being pregnant, just like you know emotionally, physically and all this stuff, I was really excited about it, I was really happy to be pregnant.

Felix also described how his ability to become pregnant conflicted with how he saw his own body:

Felix: … trying to get pregnant the first time, where I just flipped out, where some part of me didn't believe that my body was capable of it in some deep way and if it was capable of it that there was some betrayal there.

In contrast, Henry described how he attempted to use pregnancy in order to feel more connected to his body as feminine (and therefore acceptable according to dominant societal norms) before he came out as transgender:

Henry: [Before coming out to myself or others as transgender] I had a lot of magical thinking about pregnancy and what pregnancy could do. And I think it has a lot to do with the messages that are out there about birth. That pregnancy and birth are like this thing that's gonna connect you with all of womankind for all of history and that it's sort of like the most powerful thing you can do with this type of body. That applies to pregnancy and birth and then it applies further to nursing. And I'm talking about like the conversations we have societally around these things, and like I bought it – hook, line and sinker. I was like, this, this is the answer, clearly because I feel really disconnected from my body. There's something off … this [pregnancy, birth, and breastfeeding] is gonna fix it.

Seven participants reported experiencing an increase in bodily gender dysphoria due to pregnancy or birth. The ways they described their dysphoria varied considerably. Some cited gender dysphoria that was specifically related to the chest, the hips, the voice, changing muscle mass and body fat distribution, or hormonal balance, or some combination of the above.

For example, Emmett noted that experiencing gender dysphoria can be more nuanced than simply "wanting to be a man":

Emmett: I needed to teach them [health care providers] what gender dysphoria was. Yeah, I think there's that common narrative that they think oh, you want to be a man or you identify as a man but they don't really understand the physical dysphoria aspect at all because that's not really discussed in documentaries a lot … Yeah, they thought I wanted a flat chest to look like a man, not because I had gender dysphoria about my breasts. They didn't really understand that they were not breasts to me, that they were like strange tumors growing on my body.

Sometimes gender dysphoria was centered specifically around the pelvic area, and pelvic-related medical procedures or the process of giving birth became triggers. Three participants used the word "trauma" or "PTSD" to describe these experiences and their effects. One participant, Ben, specified that he would have preferred to have a c-section rather than a non-surgical birth due to anticipated gender dysphoria. However, he stated that he was unable to choose to have a c-section because it would be considered optional and not covered by insurance in his country's health system. Ben described how his health care provider exacerbated his difficulties with gender dysphoria by imposing her own narrative about giving birth:

Ben: Stupid midwife made me touch the head as well as it was coming out. She wouldn't shut up about it. She was just like go on touch it reach down and touch it I was like no no no and she was like just do it do it and grabbed my hand and everything and I was like oh God I don't want to know, please … It's even harder to dissociate myself from the situation when she's forcing me to acknowledge it … I wanted to think of it as more a clinical thing and the midwife was like no it's very spiritual and you need to connect with the earth mother.

Some participants discussed in hindsight ways that they believed their experiences of gender dysphoria during pregnancy and birth could have been lessened. Emmett mentioned that he was surprised by some of his body changes, and that if he had anticipated them, he might have coped more successfully.

Emmett: Like I thought I would have a big belly but I didn't think like that the belly would be very dysphoric. It didn't occur to me that I would have so many reverted, reverse changes, like I lost all my facial hair which has now come it's all come back but like it fell out, and I lost all my body hair, like I hardly even had any leg hair by the end of the pregnancy. I was completely back to the point of before I even started testosterone like everything went totally back. I was back to having to wear a top at the

> swimming pool and everything and it was just, and just emotionally I mean I knew that and I've always had trouble hormonally with estrogen so I knew that it would be challenging but I wasn't ready for …

Three participants speculated that had they transitioned medically to some extent (or been able to access transition) before conceiving, and thus been able to present as male during pregnancy, they might have experienced a lesser degree of gender dysphoria during pregnancy and birth.

> Julian: I think back and I think, 'wow if I had more time and space then I might have done this differently and transitioned first,' just because in a way I think it would have been a little bit easier for me.

One participant, who had transitioned after giving birth, expressed curiosity about experiencing pregnancy while presenting as male. On the other hand, another participant reported that once he was aware of his transgender identity he would never wish to carry another pregnancy, a comment that suggests he viewed pregnancy as a female task incompatible with his masculinity.

Participants discussed a variety of strategies and factors that mitigated feelings of gender dysphoria. Similar to our team's findings regarding lactation and gender identity (MacDonald, 2016), some participants mentioned the utility of pregnancy for building their family and also its temporary nature as rendering the dysphoria more manageable. One participant who experienced particularly intense gender dysphoria and depression due to body changes during pregnancy noted that additional rest improved his ability to cope.

> Alex: I was okay with who I was because I was … my body was doing a job and I was very excited about it … So my dysphoria for those, the year of being pregnant and the two and a half years of breastfeeding, my dysphoria was virtually nonexistent. Yeah it was actually quite nice.

Contrary to the dominant narrative that regards pregnancy as feminine, some study participants described pregnancy as masculine and compatible with their gender identity, or found it to belong to no particular gender. These participants reported that they did not experience an increase in gender dysphoria due to pregnancy-related body changes. This was the case for 12 of the 22 research participants. Gabby addressed this most explicitly.

> Gabby: I didn't really gender pregnancy, when I think back. I meet people sometimes, particularly female-identified people who are pregnant, and it's often a very gendered thing – "Oh, I feel so womanly." It didn't feel like that for me. It was a very ungendered thing. It felt great after the first few months when I was nauseated a lot. It felt like something really cool that my body was able to do, like a mechanical and spiritual thing, like physical but also spiritual aspect. I just didn't gender it. I didn't feel more feminine or anything like that.

While participants such as Gabby chose to view pregnancy as outside of the gender binary, refusing to categorize it as either feminine or masculine, it is interesting to note that others perceived pregnancy as fitting with a binary notion of gender but on the masculine side. Vince recognized that his feeling of pregnancy as masculine was stereotypical in a sense, and affirming of the gender binary.

> Vince: It was never something that seemed discordant with being trans or being male. I was describing it to someone the other day and just said that I won the uterus lottery. I kind of feel like that's, you know, I'm just, I got lucky … for me it was a very kind of traditionally masculine experience in that I was you know like sweaty and hungry and cranky, I mean sort of like stereotype Viking … I was building something which is sort of considered, that is sort of typified as a masculine thing or characterized as a masculine thing, so for me I think I felt more masculine [while] pregnant than I ever had before which was surprising to me.

Felix also described pregnancy as more masculine in certain ways, again upholding a binary notion of gender.

> Felix: I didn't bleed [during pregnancy] which was nice, I didn't have hips, I looked like a big trucker boy with a big belly. I totally, it actually kind of worked for my, I'm chubby anyways …

Addressing the gender binary with health care providers and hospital systems

Participants described their frustration with health care providers who believed pregnancy to be exclusively for women, a belief that influenced

the clinical care they provided. One participant, Adam, emphasized that health care providers seemed to impose their own beliefs about gender identity and pregnancy on their patients.

> Adam: When you tell someone you're transgender, it's not just telling them who you are, it's them deciding to believe you.

Adam's quote above highlights the loss of control that trans patients may experience during the childbearing year. Though a patient can opt to disclose their gender identity, the health care provider may or may not choose to affirm the information they receive, based on their own preexisting beliefs about gender and pregnancy. Two participants explicitly stated that because of their gender expression, their health care providers refused to believe basic facts about them, such as the patient's legal name and actual history of pregnancy. This disbelief on the part of HCPs leaves trans individuals in a particularly vulnerable position with regard to accessing appropriate medical care.

Some study participants anticipated that their health care providers would not hold a gender-inclusive view of pregnancy. Several chose not to disclose their gender identity while receiving prenatal care. Instead, they allowed their HCPs to assume they identified as women, in some cases stating they feared they would receive inadequate care if they did come out as transgender.

Others, like Theo, chose not to disclose their future reproductive plans at the time of medical transition:

> Theo: I was definitely going to be the one to get pregnant if we had kids and we basically, I think I kept that secret from everyone I knew, even my therapist. I didn't want to mention it to anyone because I thought that people would be like what the [expletive] are you doing being trans, you can't do that, that's impossible.

Only three participants reported having open conversations with their health care workers about their plans for future reproduction when they began medical transition. Three more participants mentioned that infertility was listed on a consent form as a possible risk of testosterone therapy, but was not discussed explicitly with a provider. When health care workers did bring up the topic of reproduction, they assumed that the only option for having genetic children would be egg preservation and eventual surrogacy, rather than carrying a pregnancy.

Kai described his physician's assumptions about hysterectomy:

> Kai: She [the physician] was like "okay, next step let's get your hysto [hysterectomy] done." I'd never thought of that as something I wanted in transition, and I remember being like, "Oh yeah. I'm trans I guess it's time to get my hysto done." So, I went to the consultation at the hospital and I remember sitting there and I was just I don't even know what I was thinking because I wasn't as self-aware back then, and one of the staff was like, "Are you excited about this?" I went home and I thought about it and I was like I don't want to do that – I want to have a baby one day. And I'm so glad, because the space that I was in I could have very easily just gotten it done and not realized that until after.

Kai's experience speaks to the complexity of negotiating being transmasculine and desiring pregnancy when health care providers may assert that a procedure that results in permanent sterilization is intrinsic to transition and transgender identity.

In one extreme example found in this study, a health care provider's strong beliefs in the gender binary and pregnancy as exclusively feminine appeared to lead to the ongoing involvement of child protective services:

> Ben: I went to a midwife [early in pregnancy], got an appointment with a midwife to get everything checked over, and she immediately referred me to social services. Yeah, that was the very first thing she did… she said, I'm going to refer you, because obviously you identify as male and this is going to be very hard for you… [The midwife said the purpose of social services' involvement was] To help me through my issues and maybe help with housing and finances and things like that, and I was like, okay, cool, that sounds fine… But then a couple of weeks down the line they suddenly turned around and said we don't believe that you're going to be a good parent basically and being transgender is going to mess the child up and we want to take her off you… they were going on about how because I want to take T [testosterone, after the birth] and I can't have T [during pregnancy] that's going to make me super stressed and then neglect my child, and I'm like, it's you guys who are making me stressed… Their [social services] argument was they have never dealt

with a trans person before, ergo they do not know how I'm going to react.

Ben reported that he and his infant were placed under a 24-hour surveillance order for a period of two months beginning when his child was born. He described receiving strong support from relatives who were able to facilitate the surveillance until it was no longer required by child protective services. Ben stated that the only reasons known to him for the surveillance order were his identity as a transgender person who experienced pregnancy, birth, and parenting, and the health and social services systems' lack of experience with transgender parents.

Assumptions about the gender binary and the inherently feminine nature of pregnancy were integral to hospitals' and insurance companies' computer systems. Emmett described how he was unable to receive the epidural he requested because the hospital's computer system would not allow a patient with a male gender marker to have the fetal monitoring necessary for the epidural. The hospital staff did not successfully work around the issue. The patient never received the epidural, much to his distress.

Oren described how his insurance company's assumptions that a man could not become pregnant represented an additional challenge for him:

> Oren: My insurance is marked as male because HR marked it as male, so everything would get kicked back, say "gender no match," like who is this dude getting an intravaginal ultrasound or whatever so, um I went to HR and she has a specific person that deals with my claims so everything goes to him now.

Felix also considered how his choices around the timing of top surgery, legal name change, legal gender marker change, and pregnancy were affected by the way that Western society's total investment in the gender binary is built into insurance schemes.

> Felix: I was stuck on whether to do [change] my name and my gender or not, and I realized that I knew I wanted to get pregnant. It was cheaper to pay for top surgery costs than pregnancy costs out of pocket and the likelihood that I would have a fight on my hands with insurance paying for pregnancy if I were male was high so there was like a whole lot of complicated decision-making around that time period about what I was doing and when.

In these instances, discrimination by individual providers but also systems-based and systemic oppression driven by procedures and presumptions diminished study participants' agency with regard to their health care.

Intersectionality

Participants noted many challenges as a result of being transgender and pregnant in a culture that insists on pregnancy as exclusively feminine, but they also described experiences of oppression and discrimination that seemed to reflect other factors including religion, age, immigration status, language, socioeconomic status and (dis)ability. Sometimes it was impossible for either the participants or the researchers to pinpoint one particular factor over another as the source of a challenging encounter. In both Emmett's and Dagan's cases, an additional aspect of their identity compounded their experience as a pregnant trans person:

> Emmett: It's really hard to untangle the issues that are just related to me being a first-time pregnant person with no other pregnant people for support in my area you know versus being trans. And being an immigrant, you know like it's really hard to disentangle all of these things. Because my immigrant experience is also a really big part of the experience.

> Dagan: [In a prenatal class] there was me and my birth partner who is blind. So there was a combination of like, "oh, I have to explain things and show things to the blind person, and then there's the trans person who wants me to use this language." She [the teacher] just couldn't even do it, she just like couldn't even do it, and I just let it go.

Four study participants expressed frustration when describing how a health care provider characterized them only in terms of their gender identity. Although many experienced heightened gender dysphoria during pregnancy, they faced other challenges simultaneously, for which they required support.

> Kai: I planned a homebirth because I wanted to see if I could do it without the drugs and I knew if I did it in the hospital I would just take the drugs because they were there. And that was my reasoning. But she [the midwife] didn't ask me, she just assumed that I didn't want to do it in the hospital because I was trans… I just wanted to be seen as a pregnant

> person first. And people are really seeing me as like a trans guy that's pregnant … I remember I had to go and get an ultrasound pretty late [be]cause they wanted to check her position and I was like … I'm a bit worried when I go to the hospital and my midwife kind of cut me off like well yeah, yeah, as a trans man, as a pregnant trans man and I stopped her and was like no, what I wanted to say was I'm worried that they're going to pressure me into inducing labour because I was late.

Kai and other participants described how they were fearful they might lose control of their health care decisions. Many told stories about being overpowered by a health care provider during childbirth. Their descriptions were recognized as commonplace by the entire research team, especially the midwife and nurses who have extensive professional experience working with cisgender women in a birthing context.

Every person who seeks care in childbirth becomes a patient who is subject to the dynamic of patient and provider (Cahill, 2001). As the study participants' narratives demonstrate, transmasculine individuals navigating the medical system may experience oppression due to the patriarchal history of the system itself, *and* they might be misunderstood or mistreated because of their transgender identity (or they may not feel safe enough to disclose their gender identity and the needs that come with it in a medical context.) In addition, there may be other aspects of their lives, such as (dis)ability, that require accommodation and inclusion. Taken together, these intersecting factors of identity often meant more to the participants in terms of their health care experience than gender identity alone.

Discussion

Our study interviews brought out tremendous detail and richness in participants' narratives. The study participants' own words are by far the most important part of our work, offering significant learning opportunities for health care providers.

Based on the accounts of our study participants, gender dysphoria might more accurately be discussed as gender dysphorias. There were nearly as many different descriptions of gender dysphoria as there were study participants, including those for whom pregnancy itself did not cause gender dysphoria, but rather felt masculine. Study participants mentioned that understanding the nuances and lived experience of gender dysphoria represented a significant gap in health care provider knowledge. This finding is similar to the result reported from our team's work on lactation, wherein participant experiences of gender dysphoria around the chest and chestfeeding varied widely (MacDonald, 2016). Our participants' in-depth quotes reported here about the sometimes masculine nature of pregnancy strongly challenge the conclusion by Charter (2018, p 74) that, "For the pregnant trans man, the materiality of the pregnant body is at odds with their identities as men and the subject position 'father.'"

Our research supports Hoffkling's (2017) finding that trans men who experience pregnancy frequently express that their health care providers failed to initiate appropriate conversations about future reproduction at the time of transition. We suggest that this omission may have to do with the broad societal assumptions that: 1) gender is binary and 2) pregnancy is feminine. Why would a health care provider discuss future pregnancy with a transgender man if pregnancy is seen as an activity for women only?

Hoffkling reported that study participants wanted more and better information about their reproductive options and the effect of transition on reproductive function, including pregnancy and milk production. In our study, the example of Kai's story is particularly striking in that health care providers not only failed to provide accurate information but assumed that sterility is a necessary part of being transgender, and pushed his choices in that direction. His experience of clinical practice represents a departure from the World Professional Association for Transgender Health standards of care, which state, " … health professionals recognized that while many [transgender] individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither … In other words, treatment for gender dysphoria has become more individualized" (Coleman et al., 2012, pp. 170-171).

Hospitals, clinics, and insurance companies must become aware of the ways in which their systems and procedures can affect the agency of

transgender patients, including the ability to obtain such basic care as an epidural during labor. When an insurance scheme or hospital provides care based on an individual's gender marker on paper instead of their physical body parts and needs, the result is that essential reproductive health services may be lacking and transgender individuals may experience a traumatic, unacceptable, and even life-threatening loss of agency and safety.

To provide excellent care to transmasculine individuals navigating pregnancy and birth, HCPs need to become educated about trans identities and furthermore, intersectional identities. Each of our study participants lived with at least two intersecting identities that could contribute to experiences of oppression and privilege – one as a transmasculine person and another as a patient in a historically patriarchal medical system. Some participants were affected by additional factors such as (dis)ability, immigration status, race, or age. Making note of these varying intersectional identities helped our research team to understand differences in the health care experiences reported by study participants. Participants living at the crossroads of many vulnerable characteristics seemed to face increased barriers when attempting to ensure respect and understanding of their transgender identity on the part of their health care providers. We suggest that education for health care providers about the effects of intersectional oppression on marginalized populations will improve HCPs' ability to provide empathetic and inclusive care during the childbearing year, instead of feeling overwhelmed by what may appear to be many needs.

Limitations

While this study provides great insight into experiences of transmasculine individuals in a variety of countries, and its international focus is a great strength, the study has limitations. As participants were primarily recruited using a closed Facebook support group for trans individuals interested in and experienced with reproduction, it meant that participants needed to have safe internet and Facebook access (from potentially abusive individuals or people with whom they were not open about their gender identities). Being a member of this Facebook group also meant that the individuals were aware that others exist who have similar interests and experiences, in terms of desiring or experiencing pregnancy. People who are private about their transition history or trans identity, and those without connection to other trans individuals likely were not aware of, nor perhaps interested in participating in the study, despite potentially having experienced a pregnancy. Interviews were conducted orally (mostly through Skype), and participants needed to have sufficient competency and fluency in English to participate.

Participant diversity is always a challenge, although we managed to involve people with an array of experiences and from five different countries. Of the demographics we considered, the most homogenous aspects were education level and socio-economic status. On a related note, with few participants from each country, and our desire to conceal participants' individual identities, we not only avoided providing specific country and ethnic information for each participant (to our readers), but we also were not able to do an assessment regarding how particular country policies, physician training, and cultural acceptance of being trans or experiencing pregnancy as masculine may impact transmasculine perinatal experiences. This further resulted in a lack of ability to thoroughly compare experiences based on country, and thus we have made no recommendations that are specific to a particular country or regional policy (ie: laws, hospital policies, health insurance companies). Instead, our findings and recommendations are more generalized, and must be assessed by locals for fit to their particular political and institutional settings.

Lastly, our study and recruitment language was limited to Western/Euro-centric framing of gender, and thus people who do not identify as transmasculine, specifically, but may have otherwise fit our inclusion criteria may not have self selected to participate (ie: Two Spirit individuals, Thai toms, and Ugandan Tommy Boys were not explicitly included, although they were also not intentionally excluded).

Conclusion

Findings from this research are significant in that they not only highlight the voices and experiences

of transmasculine individuals, but also demonstrate the heterogeneity of these voices and experiences. We found that there is not a single homogenous narrative or experience for transmasculine individuals who are subverting, reclaiming, and expanding ways of doing and knowing about reproduction. Similarly, experiences of gender dysphoria during the perinatal period were varied, and some participants found that the activities of pregnancy and birth accorded well with their masculine identity. Our participants highlighted how perinatal experiences must not be subject to standardized practices that promote microaggressions, misunderstandings, structural violence, and binary views of sex and gender. The participants' narratives help us to better understand the myriad negotiations of gender that transmasculine individuals may face when they experience pregnancy, and thus they present a learning opportunity for health care providers to better meet their diverse and unique needs.

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Disclosure statement

The authors have no conflicts of interest to declare.

Informed Consent

We obtained informed consent from all individuals participating in the study.

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